0278, expiration date 12/31/2014) data collection. The proposed pretest will test the data collection procedures involved in integrating the NHAMCS into the NHCS. NHAMCS has provided data annually since 1992 concerning the nation's use of hospital emergency and outpatient departments, and since 2009, on hospital-based ASLs and since 2010, on FSASCs. If the pretest is successful, NHAMCS will be integrated into NHCS in order to increase the wealth of data on health care utilization in hospitals across episodes of care and to allow for linkages to other data sources such as the National Death Index and data from the Centers for Medicare and Medicaid Services (CMS).

The data items to be collected from the recruited hospitals and FSASCs in the pretest will include facility level data items such as visit volume, ownership, and information on electronic health record systems. Facility- and ambulatory unit-level data will be collected through in-person interviews and recorded on computerized survey instruments. It is anticipated that each hospital will have approximately four ambulatory units and each FSASC will have one ambulatory unit.

Patient level data items will include basic demographic information, name, address, social security number (if available), and medical record number (if available), and characteristics of the patients including visit dates, reason for visit, diagnoses, diagnostic services, procedures, medications, providers seen, and disposition. Patient visit data will be abstracted by field representatives of the data collection agent. A targeted number of patient visits will be sampled from each department depending on the type of department—approximately 200 across ambulatory units in the ED, 200 across ambulatory units in the OPD, and 100 across ambulatory units in ASLs.

Secondly, the pretest will collect specific information on drug-related visits to the ED. This endeavor, funded by the Center for Behavioral Health Statistics & Quality (CBHSQ) of the Substance Abuse & Mental Health Services Administration (SAMHSA), will assess the feasibility of integrating the Drug Abuse Warning Network (DAWN) (OMB No. 0930–0078, expired 12/31/2011) into the emergency department component of the NHCS. In each of the 32 pretest hospitals with an emergency department, a sample of all patient visits will be abstracted; for each drug-related visit within this sample, additional drug-related data will be abstracted. The only burden to the respondent at the patient visit level will be due to pulling and refiling approximately 104 medical records at each ambulatory unit.

Finally, the pretest will assess the feasibility of obtaining information on colorectal cancer screening during ambulatory surgery visits where a colonoscopy is performed. This endeavor is sponsored jointly by the National Center for Chronic Disease Prevention and Promotion (NCCDPHP) and the National Cancer Institute (NCI). The questions will be added to the Ambulatory Surgery Patient Record form and will be completed for patients who have a colonoscopy performed at the sampled visit. Potential users of the NHCS ambulatory data include, but are not limited to CDC, Congressional Research Service, Office of the Assistant Secretary for Planning and Evaluation (ASPE), American Health Care Association, Centers for Medicare and Medicaid Services (CMS), Bureau of the Census, state and local governments, and nonprofit organizations. There is no cost to respondents other than their time to participate. The total burden is 381 hours.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Responses per respondent	Average burden per response (in hours)
Hospital Chief Executive Officer	Hospital Induction Interview	32	1	1.5
FSASC Chief Executive Officer	FSASC Induction Interview	15	1	30/60
Medical and Health Services Manager	Ambulatory Unit Induction	140	1	15/60
IT Staff	Prepare and transmit UB–04	47	1	1
Medical Record Clerk	Pulling and refiling records	140	104	1/60

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–12–12JM]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–7570 or send comments to Kimberly S. Lane, at 1600 Clifton Road, MS D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov*.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Improving the Health and Safety of the Diverse Workforce—New—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Stress is one of the major causes of diminished health, safety, and productivity on the job (Jordan et al,

2003; Brunner, 2000). Increasing medical care utilization costs, job dissatisfaction, poor job performance, and employee turnover are some of the documented health, economic, psychological, and behavioral consequences of stress (Levi, 1996).

Racial and ethnic minority groups often shoulder a disproportionate burden of stress-related illnesses. For example, the age-adjusted prevalence of hypertension is 40.5% among Blacks compared to 27.4% among non-Hispanic Whites. Further, some cancers are 5 times greater among Asians, Type II diabetes is 2–5 times greater among Hispanics, and depression is 4–6 times greater among Native Americans (Carter-Pokras & Woo, 2002). Few studies thus far, however, have explored factors in the workplace that may contribute to these disparities.

Because of their general concentration in high-hazard and/or lower-status occupations, some racial and ethnic minority workers may be over-exposed to workplace factors (e.g., high workload and low job control) which have traditionally linked to a variety of stress-related health and safety problems. In addition, racial and ethnic minorities appear to be significantly more likely than non-minorities to encounter discrimination and other race-related stressors in the workplace (e.g., Krieger et al, 2006; Roberts et al, 2004).

Given a potentially greater stress burden, racial and ethnic minority workers may be at heightened risk for the development of health and safety problems associated with stress. On the other hand, occupational stress research experts suggest that certain workplace and other factors (e.g., co-worker and supervisory support, anti-discrimination policies and practices, etc.) may help reduce stress among employees, including racial and ethnic minorities.

Occupational hazards have been found to be distributed differentially with workers possessing specific biologic, social, and/or economic characteristics more likely to experience increased risks of work-related diseases and injuries. Consequently, CDC/NIOSH established the Occupational Health Disparities (OHD) program. Part of the National Occupational Research Agenda (NORA), the goals of the OHD program are to conduct research ''to define the nature and magnitude of risks experienced by vulnerable populations, including racial and ethnic minorities, and to develop appropriate intervention and communication strategies to reduce these health and safety risks.''

CDC/NIOSH requests OMB approval to collect standardized information from working adults via a telephone interview. Respondents will be asked about: (1) Their exposure to workplace and job stressors, including those related to race and ethnicity (2) their health and safety status and (3) organizational (e.g., organizational characteristics, policies and practices that may or may not buffer them from the adverse effects of work-related stressors. Respondents will be a random sample of 2,300 Blacks/African Americans, White/European Americans, Hispanic/Latino Americans, American Indian/Alaska Natives, and Asian Americans. All telephone interview respondents will be between the ages of 18 and 65, English-speaking, either currently employed or unemployed for no more than 3 years, and living within the Chicago Metropolitan area. The estimated burden per response is 30 minutes.

CDC/NIOSH will use the information gather through the telephone interviews to evaluate (1) the degree of exposure of minority and non-minority workers to various workplace and job stressors (2) the impact of these stressors on health and safety outcomes and on (3) the organizational (e.g., organizational characteristics, policies and practices) and other factors that protect minority and other workers from stress and associated problems in health and safety. The data collection will ultimately help CDC/NIOSH focus intervention and prevention efforts that are designed to benefit the health and safety of the diverse American workforce. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Avg. burden per response (in hrs)	Total burden (in hrs)
Individual	Telephone Interviews	2,300	1	30/60	1,150
Total					1,150

Kimberly S. Lane,

Deputy Director, Office of Science Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

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Centers for Disease Control and Prevention

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